

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-017304

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 366

Primary Registration District No. 3059

Registrar's No. 175

STATE FILE NUMBER

FILED MAY 8 1963

1. PLACE OF DEATH a. COUNTY St Francois		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bonne Terre		c. CITY OR TOWN St Louis	
Length of stay in 1b 18 hrs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bonne Terre Hospital		d. STREET ADDRESS (If outside, give location) 8001 Allen	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Elmer Wells		4. DATE OF DEATH May 2, 1963	
First Middle Last		Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/23/1870
9. AGE (last birthday) 93		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) Patterson, Illinois		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME George Wells		13b. MOTHER'S MAIDEN NAME Etna Hubbard	
14. NAME OF HUSBAND OR WIFE Dec'd		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Charles E Wells 8001 Allen, St Louis Mo	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LEUREMIA</u> DUE TO (b) <u>Prostatic Hypertrophy</u> <u>ARTERIOSCLEROTIC HEART DISEASE</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 wk 1 yr +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour Month, Day, Year s.m. p.m.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 5-14-62 to 5-2-63 and last saw him alive on 5-2-63 Death occurred at 8:30 AM on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) C. E. Caulton M.D.	
22b. ADDRESS Farmington, Mo		22c. DATE SIGNED 5-3-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 5/4/63	
23c. NAME OF CEMETERY OR CREMATORY Pine Tree Cemetery		23d. LOCATION (City, town, or county) Whitehall, Illinois	
24. FUNERAL DIRECTOR Miller Funeral Home, Farmington, Mo.		25. DATE RECD. BY LOCAL REG. May 3, 1963	
26. REGISTRAR'S SIGNATURE Esther R. Ruff			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

USE BLACK INK

OR TYPEWRITER RIBBON

1

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 420

P. O. Address

Farmington Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

Handwritten notes:
J. H. ...
...
...